LETTERS TO THE EDITOR

Preference is given to letters commenting on contributions published recently in the *JRSM*. They should not exceed 300 words and should be typed double spaced

Medically unexplained symptoms

Dr Page and Professor Wessely should be congratulated on their exploration of medically unexplained symptoms and the doctor–patient encounter (May 2003 *JRSM*[1]). We wish to add some comments from the standpoint of a rheumatology chronic back pain clinic.

'Medically unexplained' implies a dualistic view, separating biomedical from psychosocial models. As physicians, our social role is fundamentally biomedical, and this still has value: in our clinic, 8% of a series of 657 consecutive referrals received an alternative diagnosis.[2] In many cases, the biomedical model appears insufficient to fully 'explain' a patient's symptoms. This, if perceived as a failure to fulfil the physician's proper role, can cause negative feelings in both doctor and patient. Conversely, an explanation that involves a physical mechanism appears useful in maintaining a positive doctor–patient relationship.[3] In our clinic we avoid labels such as 'fibromyalgia', which can contribute to social iatrogenesis.[4] Instead we try to provide patients with an explanatory model for their symptoms that is based on the interdependence of mind and body, with the aim of acknowledging the reality of the patient's suffering but breaking the loop of multiple unnecessary investigations.

Patient satisfaction was found in our clinic to relate as much to communication—the opportunity to discuss personal worries and future prognosis—as to the investigations performed.[5] Reassurance is not simply a matter of 'ruling out sinister causes'[6] but of directly addressing a patient's fears, particularly regarding the future.[7]

The consultation can then move on to take a pragmatic patient-centred approach to management. Guidelines developed for our clinic recommend that, to avoid engendering unrealistic hopes, doctors explain to patients that physiotherapy will not cure their pain but will help them to achieve more despite this pain. Likewise, when referring for magnetic resonance imaging, we tell the patient why—for example, explaining that we want to make sure that there is no contraindication to aggressive rehabilitation.

In this way, we try to use consultation techniques that directly address the patient's hopes, fears and expectations as well as addressing the physician's agenda of excluding other organic disease and recommending appropriate treatments.

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The review by Dr Page and Professor Wessely (May 2003 *JRSM*[1]) is timely and excellent. As they point out, medically unexplained symptoms (MUS) are probably the most common reason for attendance at general medical outpatient clinics. Yet students are not exposed adequately to this condition during either undergraduate or postgraduate training. Current medical training is so oriented as to make students always look for abnormal findings on examination. Therefore, when a doctor encounters a patient with MUS, the absence of physical abnormalities generates frustration. This is compounded by lack of effective pharmacological or surgical therapy. Very little research has been done on MUS considering the amount of suffering and financial losses they cause.

Despite the temptation to refer to multiple specialists, the best option for primary physicians is to keep patients with MUS under their own care. The lack of enthusiasm and the feeling of frustration engendered by these patients can lead to poor assessment and underinvestigation as well as multiple unnecessary investigations. Somehow a middle path has to be found. The drugs used for treatment of MUS commonly have adverse events and the mainstays of treatment are counselling, reassurance and periodic follow-up. These matters deserve detailed coverage in the medical curriculum.

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Abdominal pregnancy and lithopaedion

Irving Loudon (May 2003 *JRSM*[1]) is quite right to accept the plausibility of the French Renaissance writer Boaistau's account of a 'five-year pregnancy'. Two Renaissance physicians, d'Ailleboust and de Provanchères,[2] describe an even more remarkable case. In 1582 in the French town of Sens, a necropsy was performed on a Madame Chatri who died at the age of 68. She had become pregnant for the first and only time 28 years previously. A normal pregnancy, prolonged labour and breaking of her waters ensued without the delivery of a child. Her abdomen remained swollen, hard and painful throughout her life. At necropsy her abdomen contained a perfectly formed and calcified 'newborn' female child. An earlier *JRSM* article by Bondeson[3] recounts the story in some detail, provides copies of contemporary illustrations and traces the subsequent history of the 'stone baby'. Eminent figures who examined the baby and made drawings included Ambroise Paré[4] and Thomas Bartholin.[5] The stone baby became famous and was exhibited in various centres before disappearing from the museum of the king of Denmark during the nineteenth century.

The condition in which a fetus, probably extrauterine, remains in the abdominal cavity and becomes calcified is known as 'lithopaedion'. A Medline search of lithopaedion/lithopedion yields 56 articles which, taken together, provide information on over 300 cases. The condition is compatible with a long life expectancy and there are several instances of the mother carrying the calcified fetus for over 50 years. Recent cases are from countries deficient in obstetric and surgical care; probably many cases go unreported. For instance, the last to come to my attention was by way of a report last year in the French newspaper, *Le Figaro*: Professor Ouazzani of Rabat, Morocco, successfully removed a calcified fetus weighing four kilos from the abdomen of a woman 46 years after her last pregnancy.[6]

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6 *Le Figaro*, 28 October 2002

Effects of exposure to CS

Karagama and co-workers (April 2003 *JRSM*[1]) looked for physical sequelae in thirty-four individuals exposed to CS spray within the confines of a single decked 72-seat coach. Usefully, they divided the cohort into individuals with exposure directly onto the face and individuals with indirect exposure within the confined environment. They recorded the symptoms experienced one hour, one month, and ten months after exposure. As might have been expected,[2] the main symptoms were ocular (10 out of 10 exposed directly and 22 out of 24 exposed indirectly) followed by respiratory (10 out of 10 for the direct group and 13 out of 24 for the indirect group). Only 1 of the indirect group reported a rash whereas 3 out of 10 of the direct group reported rashes. This would concur with the report of Schmutz *et al.*[3] regarding cutaneous accidents with CS and CN: these workers concluded that, when properly suspended in air, these agents mainly affect the eyes and have only minor effects on the skin, whereas when applied directly onto the skin they produce extreme irritation with erythema and vesicles. The effects seem to develop in two stages. First there is redness and a burning sensation on the face; then, next day, oedema ensues with swelling of the eyelids. Oozing rapidly turns to crusts and, in the absence of treatment, infection is the rule. In a recent case I was supplied with dated serial colour photographs that fitted the above description. The lesions were unilateral, indicating use at very short range (also reported by Schmutz). In two previous cases, photographic evidence was lacking but the general practitioner's description in the medical records was similar and he had prescribed antibiotics prophylactically.

In their follow-up examinations at 8–10 months, Karagama *et al*. found no differences between the directly and indirectly exposed groups for respiratory or other effects, and they conclude that there was no convincing evidence of long-term physical sequelae. However, the possibility of long-term respiratory damage cannot always readily be dismissed. In 1992 Hu and Christiana[4] reported a case in which a previously healthy woman aged 21 with no wheezing or asthma or family history of asthma or atopy was inadvertently exposed to CS gas in a nightclub. From the results of spirometry over time and the response to treatment with the appropriate medication together with monitored symptoms they diagnosed the development of RADS (reactive airways dysfunction syndrome), a non-specific form of asthma that typically follows a single massive exposure to an irritant.

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What about GPs in the fight against tuberculosis?

Dr Davies's article on tuberculosis (TB) is fascinating and I agree with many of his sentiments (June 2003 *JRSM*[1]). But why were general practitioners (GPs) not mentioned in this fight against TB? I, too, have come across a patient in the past few months who almost died of meningeal tuberculosis. She was middle-aged, living with a family I had known for many years (but not registered with a GP). She developed a cough, weight loss, and sweats and finally ended up in intensive care with meningeal TB. Happily she survived and is now well. What is particularly galling is that, as a practice, we take an active interest in infectious diseases.[2] This brings me back to my main point.

Respiratory physicians cannot do all this alone; I don't know if some of Davies's comments are directed at GPs specifically (re-education of the medical and allied professionals), but general TB surveillance cannot be done without primary care. Let me say why.

I have heard it said many times that TB management should be totally within the remit of secondary care specialists. If the model of care is one that emulates HIV/AIDS care—hospital driven and directed—then please do not blame GPs for not identifying cases earlier.[3] If you involve GPs in decisions regarding their tubercular patients, then primary care can be expected to work with specialists on early identification, management and most importantly, follow-up. Since January 2003 we have registered almost 400 patients from all five continents and including war-ravaged places such as Afghanistan, Iraq, Ivory Coast, Congo as well as those countries now recovering from the effects of war such as Albania and Kosovo. This is probably why up to 40% of new cases occur in London. With this in mind, it is incumbent on all health professionals to think about TB in cases where it might be a remote, or not so remote, possibility. Davies's article would have been more compelling if GPs had been mentioned at least once.

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Maurice Ravel's amusia

In their review, Paulo Andrade and Joydeep Bhattacharya (June 2003 *JRSM*[1]) revisit the subject of Maurice Ravel's last illness. The clinical notes of his neurologist, Alajouanine,[2] indicate that Ravel developed slowly progressive apraxia and aphasia in late middle life. Although the true diagnosis will never be known, since a necropsy was not performed, the clinical picture would be compatible with one of the frontotemporal lobar dementias, possibly Pick's disease or corticobasal degeneration.[3] What does seem clear is that Ravel's difficulties were chiefly motoric and expressive, leaving his musical intellect largely unaffected. It has been suggested previously[4] that *Bolero* may represent musical perseveration, or at least a waning of Ravel's musical faculties. However, Ravel was always intensely interested in the technical aspects of his art, and there is evidence from his own correspondence that he composed *Bolero* as a study of crescendo, 'orchestration without music' (some would argue he succeeded only too well). Furthermore, the two piano concertos, completed after *Bolero*, are both masterpieces of the genre; the slow movement of the Concerto in G, in particular, is graced by a melody of Mozartian delicacy. Ravel's timbral mastery is undisputed, but he was also a melodist of rare invention, and there is little evidence that this gift deserted him even though he was tragically deprived of the means to realize his ideas. Perhaps the last words on the subject should be Ravel's own:

> 'Et puis, j'avais encore tant de musique dans la tête.'
> [And yet I still had so much music in my head]

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